

March 26, 2012

Ms. Marlene H. Dortch  
Secretary  
Federal Communications Commission  
445 12th Street SW  
Washington, DC 20554

Re: Notice of *Ex Parte* Communication, WC Docket No. 02-60

Dear Ms. Dortch:

On February 24, 2012, representatives of six projects in the FCC's Rural Health Care Pilot Program (RHCPP) spoke via telephone with Linda Oliver, Christianna Lewis Barnhart, and Chin Yoo of the Wireline Competition Bureau. These representatives were Kim Cummins, Program Coordinator, and Ken Oakley, CEO, of the Western New York Rural Area Health Education Center; Anthony Christopher of St. Joseph's Hospital in Wisconsin; Daryl Bouma of the Sanford Health Collaboration and Communication Channel (with sites in South Dakota, Iowa, and Minnesota); Kim Lamb, Project Coordinator and Executive Director; Kim Klupenger, Chief Operations Officer; and Debra Galiel, Associate Project Coordinator, of the Oregon Health Network; Mary Honicker and John Kravitz of Geisinger Health System in Pennsylvania; and Greg Davis and Cindy Turner with Bacon County Health Services in Georgia. The purpose of the call was to discuss the telecommunications needs of rural health care providers (HCPs) in response to the Commission's July 15, 2010, Notice of Proposed Rulemaking in the above-referenced docket. The group discussed their experiences with the Pilot Program and what they felt worked or could be improved upon in the future. Below is a summary of their comments.

### **Success Strategies**

*Oregon Health Network:* OHN identified three core strategies for its success: (1) use of a multi-vendor leased line network, which was instrumental in enabling them to expand their reach and obtain middle-mile connections, and helped with obtaining competitive pricing; (2) having all vendors peer at a central exchange; and (3) extensive needs assessment, communication and education among their members. Oregon observed that its network, which enables the exchange of electronic health records and telemedicine applications, ties in to the policy of coordinated patient care, which is what the whole country is driving toward. They said that this network design will provide the required infrastructure for all types of health care and health care education providers to support the integrated delivery of shared patient information, labs, images, and the expanded and improved coordination of clinical care via telemedicine.

*St. Joseph's:* Having a private fiber network as part of the larger network helped St. Joseph's to control costs and ensure long-term success, as they found that it could be cost-prohibitive to buy from a carrier the 1-10 Gbps connections needed to move medical images. Their owned facilities gave them more control of the endpoints and more service quality and reliability (though this could also have been obtained from a service provider). The Pilot Program enabled them to build on an existing community-area network. Some of the network is made up of leased lines. They also emphasized the importance of communication and education of the network members.

*Sanford:* This project upgraded from the Primary Program, where most connections were T-1s, to Ethernet services, which helped them to rollout electronic health records (EHRs). In their view, T-1s are not adequate for EHRs. It has been a real improvement to have EHRs, because Sanford is a large hospital with many points of entry and patients coming from as far as 150 miles away – so having

complete electronic health records enables the hospital to treat patients from far away more efficiently and effectively. Also, as patients move from specialty to specialty, the patient outcomes are better because all the patient information is centrally captured. The move to Ethernet leased services has provided Sanford with costs savings over the T-1 based network they had previously. Because the Pilot Program has allowed Sanford's service providers to deploy fiber, Sanford expects to continue to realize cost savings even if its health care providers have to return to primary program funding.

*Geisinger:* This project has already fully implemented EHRs and has reach Stage One Meaningful Use across its organization. (Geisinger is the recipient of a "Beacon Community" Health Information Exchange grant from the Office of the National Coordinator for Health Information Technology in the Department of Health and Human Services). It uses the pilot-funded network to provide very high intensity ICU service across their communities, as well as telestroke. These applications help them to keep patients in community settings and to sustain community hospitals. The Geisinger network has four hospitals, and but also engages in Health Information Exchange (HIE) with more than 29 other participants with varying EHR systems. The project faced challenges regarding availability of leased line fiber, given the rurality of the population it serves. There were some proactive ISPs who bid to provide those bandwidths. In some areas, the project had to bond T-1s together, as many as 7 in order to get enough bandwidth. It emphasized the importance of getting the community together and involved, and that it can take a while to win their trust. Geisinger noted that the 85% discount was helpful because although the anti-kickback regulations in the Stark Act prevent hospitals from recouping the entire cost of their networks from physician referrals, it does allow them to contribute up to 15%.

*Bacon County:* This project connects six hospitals in six counties with other rural sites, and provides a fiber connection from each hospital to the nearest access point (whichever vendor is closest). All the hospitals are connected to an Internet2 point in Atlanta. For them, the last mile is the biggest expense. Now every hospital in the network has a 1 GB connection for \$1,500 a month (the undiscounted rate), and they expect this to be sustainable.

*Western New York:* This project links five large health systems and numerous rural providers in its network, many of whom normally do not work together. The project sponsor is an area health education center (AHEC) – it serves as a neutral facilitator for this group. It also is trying to work on providing distance education and training to its members, and is serving as an advocate for rural health care providers. The champions for their project tend to be the Chief Information Officers and medical leadership, not senior administrative leaders. This project has experienced a great deal of cost savings from being on a shared network, and from having many more point-to-point connections with other institutions now that the providers are networked.

### **Network Design and Telemedicine**

Most of the projects described their networks as linking several larger hospitals with smaller rural hospitals and clinics. Western New York links health care facilities, including Federally Qualified Health Centers (FQHCs), and educational institutions in an 18-county area. It said that without its urban partners, it would be "building a road to nowhere," and that savings in travel time to such urban facilities can play a large role in cutting health care costs. It added that it is important that urban medical centers participate because creativity and innovation is located there. St. Joseph's connects two rural independent hospitals with two other hospitals. St. Joseph's also emphasized the importance of including urban institutions in the networks, stating that its network enables rural health care providers to link to the urban centers, and thus to use telemedicine, which saves patients and doctors travel time and "bends the cost curve." At this point, they are just offering teleradiology, and have purchased telehealth equipment. The billing for telehealth is not completely worked out yet.

Bacon County links six hospitals with 20 other sites and offers telestroke, teleradiology, and teletrauma services. It was able to purchase its telehealth equipment through a grant from an urban hospital in its network. The network has allowed the health care providers to contract with previously inaccessible specialists to provide specialized services (e.g. orthopedic teleradiology). Geisinger has several rural hospitals linked to 22 rural clinics. It has implemented telestroke, tele-echo, remote ICU, and telepsychiatry services.

Oregon's network links 243 health care providers, which are a mix of urban and rural, clinics and hospitals. Oregon said that including urban locations in the network is essential to the delivery of healthcare, and is the biggest strength of the pilot program. The Oregon network allows healthcare providers to implement telestroke, telepsychiatry, and pediatric ICU services over the network. The network has achieved significant cost savings from these kinds of telehealth applications. For example, through the Oregon Health Network connection, the installation and use of telemedicine applications in a rural emergency room to specialist in an urban hospital provides the opportunity for visual and audio patient consultations and improved care team decision making that include determining whether or not to transport the patient to the Portland urban hospital. A fixed wing transport within a 2 hour flight time outside of Portland costs approximately \$24,000. An ambulance within the same 2 hour boundary costs approximately \$9,000. Providing remote specialty consultations through networks like these greatly reduces life-threatening decision-making and the high costs and risks of patient transport, and improves the quality of care received. Oregon added that the other significant benefit behind remote consultation is in the ability to keep the patient in their home area close to family, and reducing the impact to the patient, their family and community as it relates to the required time away from family, school and in being able to receive support/follow up care in area

Two projects were connected to Internet2 (St. Joseph's and Bacon County). For St. Joseph's, the cost was \$84,000 annually for the gateway and Internet2 connection (the latter is \$25,000 annually of the \$84,000 total). Oregon decided not to connect due to the cost (which would have been \$25,000 annually to Internet 2 plus \$25,000 to the Oregon Gigapop, with no direct known benefit).

### **Administrative Process**

Oregon had a very good relationship with its coach, though Oregon recommended in general more training of USAC staff on telecom and telehealth technologies, in order to provide them with a greater understanding of the purpose of the services for which they are administering. In addition, Oregon recognizes and has appreciated the effort and partnership on the part of many USAC's administrative team. It estimated that its administrative expenses associated with the pilot project are \$930,000 annually. Oregon's Associate Project Coordinator, Debra Galiel, also recommended that a simpler billing, invoicing, and approval process should be implemented, noting that the current process is very cumbersome because there are so many steps.

Western New York commented on the time-consuming nature of the paperwork. It said that its direct administrative expenses for these activities cost approximately \$130,000 to \$150,000 annually, and that these expenses are not reimbursable under current Pilot Program rules. They added that network partners have contributed approximately \$65,000 towards these expenses, leaving at least \$60,000 in unreimbursed in-kind expenses that have been absorbed by Western New York annually.

St. Joseph's said that it was difficult to work through the application process because a lot was not clearly defined in advance. The overhead associated with its project was higher than anticipated. In retrospect, he said they probably should have planned a larger project and thus been able to spread the overhead over more sites. Geisinger provided information after the call regarding its administrative expenses associated with the pilot project: it estimates these to be \$42,000 annually. Bacon County stated

that its health care providers pay an additional fee that equates to approximately 3 percent of project costs to have administrative and billing functions performed.

St. Joseph's also found it easier to work with smaller vendors than with a large carrier when it came to developing an invoice that matched the network cost worksheet. Bacon County had problems trying to get an acceptable sustainability plan in place. It recommended that the quarterly reports should be simplified.

Several participants compared the pilot program with the FCC's "primary" rural health care program. They supported the simplicity of a flat rate discount (as opposed to the complexity of calculating the urban-rural differential in the FCC's primary program). Bacon County noted that calculating the urban-rural differential and mileage-based charges is difficult and subjective and, in its experience, this results in most eligible hospitals not participating in the primary program. Projects also like the consortium-based approach to application process, which they said is much easier than the process in the primary program.

Respectfully submitted,

          /s/            
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Telecommunications Access Policy Division  
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